VISION SERVICE PLAN
P.O. Box 2545001500
Sacramento, California 95865

PLACE FIRST CLASS STAMP HERE
The Post Office will not deliver mail without postage

WHO IS ELIGIBLE?

EMPLOYEE: All permanent full-time employees and permanent part-time employees who work 30 or more hours a week are eligible for this vision care plan on the first day of the calendar month following one full month of employment.

DEPENDENTS: Dependent eligibility is the same as the eligibility under your medical and dental plan.

LIMITATIONS

EXTRA COST — This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following and your VSP doctor doesn't receive prior authorization, there will be an extra charge: a) blended lenses; b) contact lenses (except as noted elsewhere herein); c) double segment bifocals; d) multifocal plastic lenses; e) oversize lenses; f) progressive multifocal lenses; or g) photochromic lenses or tinted lenses other than Pink #1 or #2.

NOT COVERED — There is no benefit for professional services or materials connected with:

1. The additional costs associated with: a) Coated lenses; b) laminated lenses; or c) a frame that costs more than the plan allowance.
2. Orthoptics or vision training and any associated supplemental testing.
3. Plano (non-prescription) lenses.
4. Glasses secured when there is no prescription change; or two pair of glasses in lieu of bifocals.
5. Supplemental testing for contact lenses.
6. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
7. Medical or surgical treatment of the eyes.
8. Services or materials provided as a result of any Workers Compensation law, or similar legislation, or obtained through or required by any government agency or program whether federal, state or any subdivision thereof.
9. Any eye examination required by an employer as a condition of employment.
10. If the covered person does not obtain the VSP benefit form in advance, but visits the panel doctor as a private patient, the panel doctor is not obligated to accept VSP fees as full payment for these services, but may elect to charge his usual and customary fees.

Arranged By
ROBERT D. CLARK, CLU
1570 The Alameda #327
San Jose, CA 95126
Phone (408) 295-6408

3/81

CHUCK E. CHEESE'S
PIZZA TIME THEATRE

Vision Care Plan

EXAMINATION
LENSES • FRAMES
PROFESSIONAL
SERVICES

VSP

VISION SERVICE PLAN

3500 American River Dr, Sacramento 95825 (916) 481-8720
3250 Wilshire Blvd, #1105, Los Angeles 90010 (213) 386-6730

THIS VISION CARE PLAN features a panel of over 10,000 doctors to provide professional vision care for persons covered under the plan. This concept assures the finest quality professional care and materials, at a uniform cost.

WHAT ARE THE BENEFITS?

VISION EXAMINATION: A complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities.

LENSES: The VSP Panel Doctor will order the proper lenses (only if needed). The program provides the finest quality lenses fabricated to exacting standards. The doctor also verifies the accuracy of the finished lenses.

FRAMES: The plan offers a wide selection of frames, however, if you select a frame which costs more than the amount allowed by your plan there will be an additional charge.

NECESSARY CONTACT LENSES: Contact lenses are furnished under the VSP plan when the VSP Panel Doctor secures prior approval for the following conditions: a) Following cataract surgery. b) To correct extreme visual acuity problems that cannot be corrected with spectacle lenses. c) Anisometropia. d) Keratoconus. When VSP Panel Doctors receive approval for such cases, they are fully covered by VSP.

COSMETIC CONTACT LENSES: When patients choose contact lenses for other reasons, VSP will make an allowance of $75 toward their cost in lieu of all other benefits (examination, lenses and frame) for that eligibility period, as outlined under "HOW OFTEN ARE THESE SERVICES AVAILABLE".

HOW MUCH DO I PAY?

When you select a doctor from the VSP list, this plan covers the visual care described herein (examination, professional services, lenses and frame) at no expense to you except a deductible of $25.00. Any additional care, service and/or materials not covered by this plan may be arranged between you and the doctor.

HOW DO I USE THIS PLAN?

1. To obtain vision care, fill out and mail the attached card. If you are eligible for vision care under this plan, a benefit form will be sent to you along with a list of panel doctors in your area.

CAUTION: You should not make an appointment for vision care services until you obtain the benefit form.

2. Select the doctor of your choice from the list and make an appointment for an examination. Present your benefit form on your first visit.

3. When the examination has been completed the doctor will have you sign your name in the space provided. Pay only $25.00 to the doctor for the services described herein. VSP will pay the panel doctor directly according to their agreement with the doctor.

4. Selecting a doctor from the VSP list assures direct payment to the doctor and a guarantee of quality and cost control. However, if you seek the services of a doctor who is ***NOT*** a VSP Panel Member, you should pay the doctor his full fee. You will be reimbursed in accordance with a reimbursement schedule. ***THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE GLASSES. REIMBURSEMENT BENEFITS ARE NOT ASSIGNABLE.***

NOTE: When you obtain service from a doctor who is not a VSP Panel Member, and/or obtain glasses from a dispensing optician, be sure to send your itemized statement of charges to VSP along with your benefit form.

HOW OFTEN ARE THESE SERVICES AVAILABLE?

VISION EXAMINATION: Every 12 months.
LENSES: Every 24 months only if needed.
FRAMES: Every 24 months only if needed.

IMPORTANT Please **do not** make an appointment for eye care **before** sending in this card and receiving your Benefit Form.

IMPORTANT: Mail Request Card BEFORE You Make Eye Care Appointment. VSP Will Send You A Benefit Form and List of Doctors

VISION SERVICE PLAN — REQUEST FOR VISION CARE
Pizza Time Theatre, Inc. 610-002

Please Print or Type

Box 1

Employee's Name _____ Last _____ First _____ Middle _____ Social Security No. _____ Year Born _____
Home Address _____ Street _____ City _____ State _____ Zip _____ Phone _____

Box 2

COMPLETE A REQUEST FOR EACH PERSON WHO NEEDS VISION CARE AT THIS TIME

Benefits requested for (Check ONLY One):
☐ Employee
☐ Spouse (Name _____)
☐ Child or (Relationship _____)
Date of Birth _____
If child over age 19 and attending school full-time, give name of school _____
Do you have another plan that provides vision care?
☐ No ☐ Yes ☐ VSP _____ ☐ Other _____

VSP Billed
Do not write in this space
Authorized By _____
Date _____

Box 3

I wish to see a doctor in (City or County) _____ (State) _____ (Zip) _____

Employee's Signature _____
Date _____

PIZZA TIME THEATRE VISION CARE PLAN

Date of Origin: 1982
Archived: 5-21-12
Submission by Tristan R.
Version 1.0

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